Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: FORT DUNCAN REGIONAL MEDICAL CENTER 3255 WEST PIONEER PARKWAY ARLINGTON TX 76013	MFDR Tracking #: M4-10-3216-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: EAGLE PASS I S D Rep Box #: 29	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility $2310.50 for the seven line items listed for the MAR at 200%. Insurance only paid $1515.24. Insurance is short $764.26. We request additional payment of $764.26."

Principle Documentation:

1. DWC 60 package
2. Hospital Bill(s)
3. Explanation of Benefits (EOBs)
4. Medical Records
5. Total Amount Sought $764.26

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: " The carrier maintains that the bill for medical services made the basis of this claim have not been 'underpaid.' An additional review which resulted from this medical fee dispute has determined that in fact, the carrier has overpaid the billing by $37.07 for which the carrier seeks reimbursement."

Principle Documentation:

1. Response package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
05/06/09	**Hospital Outpatient Surgical Services**	**Total APC MAR is $1,232.71 x 200% = $2,465.72 - $2,469.36 (Paid by Respondent) = $0.00. (Due Requestor)**	$764.26	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and meets the requirements for medical dispute resolution under 28 TAC §133.305 (a)(4).

1. The disputed services were denied or reduced by the insurance carrier based upon:

   Explanation of benefits dated 07/03/09 noted claim reduction codes:
   - W1 — Charge exceeds Fee Schedule allowance.
   - 97 — Items and/or services are packaged into APC rate. Therefore, there is no separate APC payment.

   Explanation of benefits dated 09/15/09 noted claim reduction codes:
   - 193 — Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W1 — Workers Compensation State Fee Schedule Adjustment.
   - W3 — Additional payment made on appeal/reconsideration.

2. The respondent asserts in their position summary of their response to the DWC 60 that the carrier has overpaid the billing by $37.07 for which the carrier seeks reimbursement. However, no documentation was found to support communication of sufficient, specific detail to notify the requestor of the issue or question related to the medical bill refund request. This request for a refund by the respondent is not supported.

3. Division rule at 28 TAC §134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables."

4. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."

5. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:

   (1) No documentation was found to support a contractual agreement between the parties to this dispute;

   (2) MAR can be established for these services; and

   (3) Separate reimbursement for implantables was *NOT* requested by the requestor.

6. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.

7. The requestor lists CPT codes 70450, 72125, 72193, 74160, 76374, 76375, and 99284-25 as the codes in dispute.

8. CPT code 70450, billed under Revenue code 0350 is considered a Status S code. This Code has a payment indicator of S which relates to services or procedures not subject to multiple procedure discounting.

9. CPT codes 72125, 72193 and 74160, billed under Revenue Code 0350 are considered Status N codes. This Code has a payment indicator of N which relates to services or procedures included in the APC rate, but NOT paid separately (this is a packaged item). No reimbursement is allowed for this code.

10. CPT code 96374, billed under Revenue code 0450 is considered a Status S code. This Code has a payment indicator of S which relates to services or procedures not subject to multiple procedure discounting. CPT code 96374 is considered per the Correct Coding Initiative (CCI) edits to be a component procedure of CPT code 99284 which was billed on the same date of service. A modifier is allowed in order to differentiate the service provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. Review of the submitted documentation finds that the requestor did not bill the disputed service with a modifier, therefore separate payment cannot be recommended.
11. CPT code 96375, billed under Revenue code 0450 is considered a Status S code. This Code has a payment indicator of S which relates to services or procedures not subject to multiple procedure discounting. CPT code 96374 is considered per the Correct Coding Initiative (CCI) edits to be a component procedure of CPT code 99284 which was billed on the same date of service. A modifier is allowed in order to differentiate the service provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. Review of the submitted documentation finds that the requestor did not bill the disputed service with a modifier, therefore separate payment cannot be recommended.
12. CPT code 99284-25, billed under Revenue code 0450 is considered a Status V code. This Code has a payment indicator of V which relates to clinic or emergency department visits which may include ER physician or personal physicians.
13. Consequently, reimbursement will be calculated in accordance with Division rule at 28 TAC §134.403(f)(1)(A) as follows:

    APC Medicare Facility Specific Amount including Outlier Payment Amount is $1,232.71 X 200% = $2,465.72 less Amount Paid by Respondent $2,469.36 = Additional Amount Due to Requestor $0.00.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Rule §134.403, §133.307 and §133.305

PART VII: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

		August 26, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.